

Home Environmental Checklist (HEC)

Allies Against Asthma

A1. Assessor's Name: _____

A2. Date: ____/____/____

A2a. Return Visit Date: ____/____/____ *(if needed)*

A3. Address: _____ City: _____ ZIP code: _____

A4. Caretaker's Name: _____
First LastA5. Child's Name: _____
First Last

A6. Starting Time: ____:____ AM/PM

A7. Building construction year: _____ (via iMap) *(Attach printout to paperwork)**(During the course of the interview, record temperature below)*

O

Living room or common family space	Child's bedroom	Hot water from kitchen sink
---------------------------------------	-----------------	--------------------------------

A8.

Temperature a. _____ b. _____ c. _____

Interviewer: for this questionnaire, the methods of getting information are:**O = observation only, A = ask client, A+O = ask and observe**

Interviewer: complete this page before entering the home.

BUILDING EXTERIOR/OUTSIDE

1. Do you see any problems with the roof (for example sagging, holes, or missing materials)?

- O** Yes1
No2
Can't see entire roof.....9

2. Do you see any walls with missing bricks, siding, shingles, etc.?

- O** Yes1
No2

3. Is any paint peeling or flaking on the outside of the house?

- O** Yes1
No2

4. Does water spill onto siding or foundation because of malfunctioning or absent gutters and/or downspouts?

- O** Yes1
No2

5. Is soil or vegetation in contact with the siding of the house?

- O** Yes1
No2

6. Is there accumulated garbage or debris on the property?

- O** Yes1
No2

For interviewer to read➤: The purpose of this interview is to collect information about your home environment as it relates to your child's asthma and safety. Most of the questions are designed to guide the type of help you will receive. Other questions are to let us know if what we are doing makes a difference for the community.

If there is a question you do not want to answer, please let me know and we can skip it. All of your responses are confidential and will not affect any of the services you receive at the clinic or from your provider.

After the interview questions, we will walk through several rooms in the house with you to make some observations.

B. PARTICIPANT ACTIONS

I will now ask you some questions about things some people do in their homes to help control asthma triggers. There is no right or wrong answer, just tell me what YOU do.

Now please tell me some things you do to:

	None ₀	Don't know ₉
B1. Lower exposure to dust mites		
B2. Keep roaches out of your home		
B3. Keep rodents (mice and rats) out of your home		
B4. Keep mold and moisture out of your home		
B5. Keep pets from making your child's asthma worse		
B6. Keep pollens from making your child's asthma worse		
B7. Some people use bleach to get rid of mold. If you do, how much bleach do you add to a gallon of water to make a safe, effective mold cleaning solution? [A gallon is the size of a large plastic milk container.] Amount: _____ Don't use bleach _____ Don't know _____		

C. GENERAL QUESTIONS

The purpose of the following questions is to look at the environment in your home and how it relates to your child's asthma as well as the health of other household members.

A C1. How many people usually live in the home? # _____
(including all adults and children)

A C2. Where does [CHILD] usually sleep?
 Bedroom1
 Living room/family room2
 Other3 Specify _____

◀For interviewer to read▶: Next, I would like to ask you some questions related to dust, cleaning, and washing.

O + A a. Remove their shoes? ☐ ₁ Yes ☐ ₂ No ☐ ₃ Sometimes

D2. Do you now have a working vacuum cleaner in the house?

O + A Yes.....1 **Brand:**_____

Model#:_____ **Bag:**_____

No.....2 ➡ Skip to D6

D3. Does the vacuum have a special air filter, such as a HEPA filter, to keep dust in the vacuum?

O ☐₁ Yes ☐₂ No ☐₉ Don't know

◀For interviewer to read▶ The next questions are about things you did to clean your house **during the last 14 days**. [None=0, DK=99].

During the LAST 14 DAYS, how many times did you or anyone in the home Times/14 days

A D4. Vacuum the floor of the room in which [CHILD] sleeps? # _____

A D5. Vacuum or wash the cloth-covered furniture in the home? # _____
(if no cloth covered furniture, enter 98)

A D6. Dust the room in which [CHILD] sleeps? # _____

A D7. Scrub the tub or shower wall in the bathroom? # _____

A D7a. What do you use to scrub the tub or shower wall in the bathroom? (Read choices)

Tilex or other store bought cleaner..... ☐₁ Yes ☐₂ No

Bleach and water solution..... ☐₁ Yes ☐₂ No

Detergent and water..... ☐₁ Yes ☐₂ No

Plain water..... ☐₁ Yes ☐₂ No

Other ↗Specify _____

During the LAST 14 DAYS, how many times did you or any one in the home # Times/14 days

A D8. Sweep, mop, dust or vacuum the kitchen or cooking area floor? # _____

A D9. Clean the kitchen counter? # _____

A D10. Wash or freeze your child's stuffed animals? # _____
[If no stuffed animal, enter 98]

A D11. Wash your child's sheets and pillowcases? # _____
[If no pillows, enter 98]

A D12. Wash your child's pillows? # _____

A D13 Where do you usually do your laundry?

At home1

In another home2

In a Laundromat3

Other4

- A** D14. When you wash [CHILD]'s sheets and pillow cases what temperature do you use for the
(Circle number) a. Wash cycle? b. Rinse cycle?

Hot1.....1
Warm2.....2
Cold.....3.....3
Don't Know.....9.....9

◀**For interviewer to read**▶ During the last **12 months**, how many times did you.

- A** D15. Wash the cover on your child's bed (i.e. blankets/spreads/ comforters)?

Number of times.....#_____

Other98 ⚡Specify_____

Don't know99

- A** D16. How do you clean area rugs? (*Check all that apply*)

- a. ☐ Vacuum surface
- b. ☐ Vacuum both sides
- c. ☐ Shake
- d. ☐ Send out
- e. ☐ Wash
- f. ☐ Other ⚡Specify_____
- g. ☐ Don't clean them
- h. ☐ No area rug



E. VENTILATION AND MOISTURE

◀**For interviewer to read**▶: Next are some questions about ventilation and moisture in your home.

E1. First, how often do windows other than bathroom and kitchen fog up? Would you say:

A (Read responses)

Never5

Rarely4

Sometimes.....3

Most of the time2

Always1

Don't Know9

E2. Does the bathroom window or mirror stay fogged up for more than 15 minutes

A after the shower is used?

☐ ₁ Yes ☐ ₂ No ☐ ₉ Don't know

E3. Do you use a humidifier/vaporizer in the home?

A + O ☐ ₁ Yes ☐ ₂ No ☐ ₉ Don't know



F. PETS AND PESTS

◀For interviewer to read▶: Next I would like to ask you some questions about pets.

F1. Do you have any pets, such as dogs, cats, rabbits, birds, hamsters/gerbils/other rodents or others? _____

Does it/Do they come inside? _____

Does it/Do they come inside the child's sleeping room? _____

◀For interviewer to read▶: Next I would like to ask you some questions about cockroaches, and mice or rats.

F2. Do you have cockroaches in your home now? ☐ ₁ Yes ☐ ₂ No ☐ ₉ Don't Know

A If yes, has anything been done about it? _____

F3. Have you had any problems with mice or rats in your home now? ☐ ₁ Yes ☐ ₂ No ☐ ₉ Don't Know

A If yes, has anything been done about it? _____

HOME WALK-THROUGH

◀For interviewer to read▶ Now I would like to walk through several rooms of your home with you. I will be making observations, looking under sinks in the kitchen and bathroom, and recording information about these rooms. I will also be asking you questions related to specific items in some of the rooms we will be surveying. Is it okay to start with your child's bedroom?



G. CHILD'S BEDROOM/SLEEPING AREA

G1. At what temperature do you keep this room during the heating season? _____ °F

A (Enter 98 if the heater does not work)

G2. Does the object (bed, mattress, etc.) on which [CHILD]

A + O usually sleeps have a zippered allergy control cover? ☐ ₁ Yes ☐ ₂ No

G3. Does the pillow have a zippered allergy control cover? ☐ ₁ Yes ☐ ₂ No ☐ ₃ No pillow

Interviewers: Please complete the HOME ASSESSMENT CHECK LIST for child's bedroom/sleeping area.

A + O All questions are "O" except where "ASK" is stated.

Child's Bedroom		Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> ₁ Carpeting <input type="checkbox"/> ₂ Hardwood, tile, linoleum or vinyl <input type="checkbox"/> ₃ Other	
Carpet type:	<input type="checkbox"/> ₁ Level loop <input type="checkbox"/> ₂ Shag or plush	
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____	
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____	
Can at least one window be opened?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Ask: When weather allows, do you open the window to ventilate?	<input type="checkbox"/> ₁ Always <input type="checkbox"/> ₂ Most times <input type="checkbox"/> ₃ Sometimes <input type="checkbox"/> ₄ Never	
Types of window covering:	<input type="checkbox"/> ₁ Curtains/drapes <input type="checkbox"/> ₂ Blinds or shades <input type="checkbox"/> ₃ Not applicable	
Optional safety	Is the window fall-proof?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No

Child's Bedroom		Mark Correct Answer
Level of dust on surface in the room	<input type="checkbox"/> ₁ None <input type="checkbox"/> ₂ Slight <input type="checkbox"/> ₃ Moderate <input type="checkbox"/> ₄ Heavy	
Optional safety	Notice any electrical cords in poor condition?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
	Do radiators have safety covers?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₉ Not Applicable

Structural problems	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Holes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Peeling paint	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Other	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, specify:	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <hr/>
▶▶ If any structural problems, mold or leak, <u>ask</u> :	
Have you tried to fix the problem yourself?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did you do?	<hr/>
	<hr/>
Have you asked your landlord to fix the problem?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did he/she do?	<hr/>
	<hr/>
	<hr/>

Child's Bedroom		Mark Correct Answer
<u>Are any of the following odors present?</u>		
Tobacco	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Mold	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Fragrance (air freshener)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Candles/incense	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Strong smelling cleaner or chemical	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No:	
Other	<hr/> ▶▶ If yes, specify below	
<hr/>		
<u>See evidence of</u> (in the room and closet)		
Water damage	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Condensation	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Water leaks/drips	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Water leak source	<input type="checkbox"/> ₁ Outside <input type="checkbox"/> ₂ Inside	

ID# _____

5-7-03

See evidence of (in the room and closet) Mold/mildew Location	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No ➤ If yes, record items below
	<input type="checkbox"/> ₁ ≤ 10 ft ²
	<input type="checkbox"/> ₂ >10 ft ²
	Intensity <input type="checkbox"/> ₁ Slight <input type="checkbox"/> ₂ Moderate <input type="checkbox"/> ₃ Severe

See evidence of (in the room and closet) Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Rodents (or droppings)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	



H. LIVING ROOM/FAMILY ROOM

◀For interviewer to read▶ Next, let's have a look at the living room.

Please complete the **HOME ASSESSMENT CHECK LIST** for the living room or family room.

Living Room/Family Room	Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> ₁ Carpeting <input type="checkbox"/> ₂ Hardwood, tile, linoleum or vinyl <input type="checkbox"/> ₃ Other
Carpet type:	<input type="checkbox"/> ₁ Level loop <input type="checkbox"/> ₂ Shag or plush
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____
Can at least one window be opened?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
<u>Ask:</u> When weather allows, do you open the window to ventilate ?	<input type="checkbox"/> ₁ Always <input type="checkbox"/> ₂ Most times <input type="checkbox"/> ₃ Sometimes <input type="checkbox"/> ₄ Never
Types of window covering:	<input type="checkbox"/> ₁ Curtains/drapes <input type="checkbox"/> ₂ Blinds or shades <input type="checkbox"/> ₃ Not applicable
<div style="background-color: #cccccc; padding: 2px; display: inline-block;">Optional safety</div> Is the window fall-proof ? [optional safety]	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No

Living Room/Family Room		Mark Correct Answer
Level of dust on surface in the room	<input type="checkbox"/> ₁ None <input type="checkbox"/> ₂ Slight <input type="checkbox"/> ₃ Moderate <input type="checkbox"/> ₄ Heavy	
Optional safety	Notice any electrical cords in poor condition?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
	Do radiators have safety covers?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Not Applicable

Structural problems	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Holes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Peeling paint	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Other	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, specify:	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <hr/>
▶▶ If any structural problems, mold or leak, <u>ask</u> :	
Have you tried to fix the problem yourself?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did you do?	<hr/> <hr/>
Have you asked your landlord to fix the problem?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did he/she do?	<hr/> <hr/>

Living Room/Family Room	Mark Correct Answer	
Are any of the following odors present?		
Tobacco	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Mold	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Fragrance (air freshener)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Candles/incense	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Strong smelling cleaner or chemical	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No:
Other	_____ ▶ If yes, specify below	
See evidence of (in the room and closet)		
Water damage	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Condensation	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Water leaks/drips	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Water leak source	<input type="checkbox"/> ₁ Outside	<input type="checkbox"/> ₂ Inside
See evidence of (in the room and closet)		
Mold/mildew	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No ▶ If yes, record items below
Location	_____	

	<input type="checkbox"/> ₁ ≤ 10 ft ²	Intensity
	<input type="checkbox"/> ₂ >10 ft ²	<input type="checkbox"/> ₁ Slight
		<input type="checkbox"/> ₂ Moderate
		<input type="checkbox"/> ₃ Severe

See evidence of (in the room and closet)		
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Rodents (or droppings)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No

I. THE KITCHEN

◀**For interviewer to read**▶ Next, let's have a look at the kitchen.

I1. Is there a hood/vent with a working fan present over the stove/oven? (*Turn on fan to test*)

- A + O** Yes.....1
 No2 ➡Skip to CHECKLIST
 Don't know.....9 ➡Skip to CHECKLIST

I2a. Is the hood or vent over the stove ventilated to the outside?

A + O (*Look at outside wall if possible to see if vent is in place*)

- ☐₁ Yes ☐₂ No ☐₉ Don't know

I2b. How often is the fan or vent used when the stove is in use? Would you say:

- A** Always1
 Most of the time2
 Sometimes.....3
 Rarely4
 Never5
 Don't Know9

O I2c. Do the toilet paper test: Is the suction in the fan adequate?

- ☐₁ Yes ☐₂ No ☐₉ Don't know



Please complete the home assessment **CHECKLIST** for the kitchen.
Remember to measure **hot water temperature** and record on the face sheet.

Kitchen	Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> ₁ Carpeting <input type="checkbox"/> ₂ Hardwood, tile, linoleum or vinyl <input type="checkbox"/> ₃ Other
Carpet type:	<input type="checkbox"/> ₁ Level loop <input type="checkbox"/> ₂ Shag or plush
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____
Can at least one window be opened?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
<u>Ask:</u> When weather allows, do you open the window to ventilate?	<input type="checkbox"/> ₁ Always <input type="checkbox"/> ₂ Most times <input type="checkbox"/> ₃ Sometimes <input type="checkbox"/> ₄ Never
Types of window covering:	<input type="checkbox"/> ₁ Curtains/drapes <input type="checkbox"/> ₂ Blinds or shades <input type="checkbox"/> ₃ Not applicable
Is the window fall-proof?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No

Optional
safety

Kitchen	Mark Correct Answer
Level of dust on surface in the room	<input type="checkbox"/> ₁ None <input type="checkbox"/> ₂ Slight <input type="checkbox"/> ₃ Moderate <input type="checkbox"/> ₄ Heavy
Notice any electrical cords in poor condition?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Do radiators have safety covers?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Not Applicable

Optional
safety

Structural problems

Cracks (larger than thickness of a dime)

☐₁ Yes☐₂ No

Holes

☐₁ Yes☐₂ No

Peeling paint

☐₁ Yes☐₂ No

Other

▶▶ If yes, specify:

☐₁ Yes☐₂ No

▶▶ If any structural problems, mold or leak, ask:

Have you tried to fix the problem yourself?

☐₁ Yes☐₂ No

▶▶ If yes, what did you do?

Have you asked your landlord to fix the problem?

☐₁ Yes☐₂ No

▶▶ If yes, what did he/she do?

Kitchen	Mark Correct Answer	
Are any of the following odors present?		
Tobacco	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Mold	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Fragrance (air freshener)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Candles/incense	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Strong smelling cleaner or chemical	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No:
Other	_____ ▶ If yes, specify below	
<hr/>		
See evidence of (in the room and closet)		
Water damage	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Condensation	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Water leaks/drips	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Water leak source	<input type="checkbox"/> ₁ Outside	<input type="checkbox"/> ₂ Inside
See evidence of (in the room and closet)		
Mold/mildew	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No ▶ If yes, record items below
Location	_____	

	<input type="checkbox"/> ₁ ≤ 10 ft ²	Intensity
	<input type="checkbox"/> ₂ >10 ft ²	<input type="checkbox"/> ₁ Slight
		<input type="checkbox"/> ₂ Moderate
		<input type="checkbox"/> ₃ Severe

See evidence of (in the room and closet)		
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Rodents (or droppings)	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No

J. THE BATHROOM

◀For interviewer to read▶ Let's visit the bathroom [CHILD] uses most

J1. Is there a working fan in the bathroom? (*Turn on the fan to test*)

A + O Yes1
 No2 ➔Skip to K2

J1a. ▶▶ If yes, how often is the fan used during and after a shower? Would you say:

A Always1
 Most of the time2
 Sometimes.....3
 Rarely4
 Never5
 Don't Know9

J1b. Do the toilet paper test: Is the suction in the fan adequate?

A + O ☐₁ Yes ☐₂ No

J1c. Is the fan vented to the outside? (*Check outside to see if vent is visible*)

A ☐₁ Yes ☐₂ No ☐₃ Don't know

J2. Are there cracks or spaces around the tub, shower or sink caused by inadequate caulking, missing tiles, etc.?

O ☐₁ Yes ☐₂ No

➡ Please complete the home assessment **CHECKLIST** for the bathroom.

Bathroom		Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> ₁ Carpeting <input type="checkbox"/> ₂ Hardwood, tile, linoleum or vinyl <input type="checkbox"/> ₃ Other	
Carpet type:	<input type="checkbox"/> ₁ Level loop <input type="checkbox"/> ₂ Shag or plush	
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____	
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____	
Can at least one window be opened?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Ask: When weather allows, do you open the window to ventilate?	<input type="checkbox"/> ₁ Always <input type="checkbox"/> ₂ Most times <input type="checkbox"/> ₃ Sometimes <input type="checkbox"/> ₄ Never	
Types of window covering:	<input type="checkbox"/> ₁ Curtains/drapes <input type="checkbox"/> ₂ Blinds or shades <input type="checkbox"/> ₃ Not applicable	
Optional safety	Is the window fall-proof?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No

Bathroom		Mark Correct Answer
Level of dust on surface in the room	<input type="checkbox"/> ₁ None <input type="checkbox"/> ₂ Slight <input type="checkbox"/> ₃ Moderate <input type="checkbox"/> ₄ Heavy	
Optional safety	Notice any electrical cords in poor condition?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
	Do radiators have safety covers?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Not Applicable

Structural problems	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Holes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Peeling paint	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Other	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, specify:	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No

▶▶ If any structural problems, mold or leak, <u>ask</u> :	
Have you tried to fix the problem yourself?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did you do?	_____

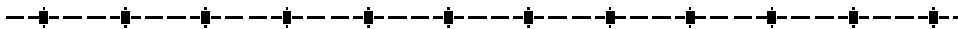
Have you asked your landlord to fix the problem?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did he/she do?	_____

Bathroom	Mark Correct Answer
Are any of the following odors present?	
Tobacco	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Mold	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Fragrance (air freshener)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Candles/incense	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Strong smelling cleaner or chemical	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No:
Other	_____ ▶▶ If yes, specify below

See evidence of (in the room and closet)	
Water damage	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Condensation	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Water leaks/drips	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Water leak source	<input type="checkbox"/> ₁ Outside <input type="checkbox"/> ₂ Inside

See evidence of (in the room, especially behind toilet and under sink, as well as walls and windows)	Mold/mildew	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No ➤ If yes, record items below
	Location	<div> <input type="checkbox"/>₁ ≤ 10 ft² </div> <div> <input type="checkbox"/>₂ >10 ft² </div> <div> Intensity <input type="checkbox"/>₁ Slight <input type="checkbox"/>₂ Moderate <input type="checkbox"/>₃ Severe </div>

See evidence of (in the room and closet)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Rodents (or droppings)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	

**K. BASEMENT or CRAWL SPACE**

K1. If the basement floor is carpeted, is there a vapor barrier under the carpet?

A + O ☐₁ Yes ☐₂ No ☐₉ Don't know ☐₈ Not carpeted

K2. Is there a crawl space under the house?

A + O Yes1
No2 ➡ Skip to CHECKLIST

K3. Does the crawl space have vents?

A + O ☐₁ Yes ☐₂ No

K4. Is the crawl space wet or damp?

A + O ☐₁ Yes ☐₂ No ☐₃ Can't access

K5. Is there a moisture barrier in the crawl space?

A + O ☐₁ Yes ☐₂ No ☐₃ Can't access

Stop and go to the checklist for the basement



Please complete the home assessment **CHECKLIST** for the **basement** if **basement is used as a living space**. If the basement **is not used for living space**, answer questions in **the odor and evidence boxes only**.

Basement	Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> ₁ Carpeting <input type="checkbox"/> ₂ Hardwood, tile, linoleum or vinyl <input type="checkbox"/> ₃ Other
Carpet type:	<input type="checkbox"/> ₁ Level loop <input type="checkbox"/> ₂ Shag or plush
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No # _____
Can at least one window be opened?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Ask: When weather allows, do you open the window to ventilate ?	<input type="checkbox"/> ₁ Always <input type="checkbox"/> ₂ Most times <input type="checkbox"/> ₃ Sometimes <input type="checkbox"/> ₄ Never
Types of window covering:	<input type="checkbox"/> ₁ Curtains/drapes <input type="checkbox"/> ₂ Blinds or shades <input type="checkbox"/> ₃ Not applicable

Basement	Mark Correct Answer
Level of dust on surface in the room	<input type="checkbox"/> ₁ None <input type="checkbox"/> ₂ Slight <input type="checkbox"/> ₃ Moderate <input type="checkbox"/> ₄ Heavy
Optional safety: Notice any electrical cords in poor condition?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Do radiators have safety covers?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Not Applicable

Structural problems	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Holes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Peeling paint	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Other	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, specify:	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No

▶▶ If any structural problems, mold or leak, <u>ask</u> :	
Have you tried to fix the problem yourself?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did you do?	_____

Have you asked your landlord to fix the problem?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
▶▶ If yes, what did he/she do?	_____

 **Odor & evidence boxes follow – complete these sections for basements used as living space.**

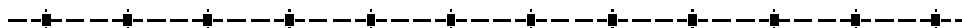
Basement	Mark Correct Answer
<u>Are any of the following odors present?</u>	
Tobacco	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Mold	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Fragrance (air freshener)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Candles/incense	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Strong smelling cleaner or chemical	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No:
Other	_____ ▶▶ If yes, specify below

<u>See evidence of</u> (in the room and closet)	
Water damage	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Condensation	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Water leaks/drips	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
Water leak source	<input type="checkbox"/> ₁ Outside <input type="checkbox"/> ₂ Inside

See evidence of (in the room and closet) Mold/mildew Location	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No ➤ If yes, record items below

	<input type="checkbox"/> ₁ ≤ 10 ft ² Intensity <input type="checkbox"/> ₂ >10 ft ² <input type="checkbox"/> ₁ Slight <input type="checkbox"/> ₂ Moderate <input type="checkbox"/> ₃ Severe

See evidence of (in the room and closet) Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Rodents (or droppings)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	



L. HEAT SOURCE

(Use the table below to record answers)

◀For interviewer to read> **Next, I would like to ask you some questions about the heat sources in your home.**

A + O QUESTIONS TO THE RIGHT	L1. Filter on air intake A + O	L1a. How clean? O
1a. Electric – furnace	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Don't know	<input type="checkbox"/> ₁ Clean <input type="checkbox"/> ₂ Partially dirty <input type="checkbox"/> ₃ Dirty <input type="checkbox"/> ₄ Unable to observe
b. Gas	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Don't know	<input type="checkbox"/> ₁ Clean <input type="checkbox"/> ₂ Partially dirty <input type="checkbox"/> ₃ Dirty <input type="checkbox"/> ₄ Unable to observe
c. Oil	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Don't know	<input type="checkbox"/> ₁ Clean <input type="checkbox"/> ₂ Partially dirty <input type="checkbox"/> ₃ Dirty <input type="checkbox"/> ₄ Unable to observe
d. Wood stove fireplace		

M. OTHER**<For interviewer to read>** Now, some other questions.

M1. Do you have a working clothes dryer in the home?

A Yes1
No2 ➔Skip to O2M1a. Is it vented on the outside? (*Check on outside wall to see if there is a vent*)**A + O** ☐₁ Yes ☐₂ No ☐₃ Don't know**N. CHEMICALS AND IRRITANTS****N1. Do you have anything in your home that has a strong odor or that irritates your child's asthma or makes the asthma worse, such as:**a. Cleaning products that contain bleach or ammonia ☐₁ Yes ☐₂ Nob. Paint products, solvents, glue ☐₁ Yes ☐₂ Noc. Air fresheners, scented candles, incense ☐₁ Yes ☐₂ No

Optional

 d. Pesticides (Don't make asthma worse but are toxic) ☐₁ Yes ☐₂ Noe. Other: _____ ☐₁ Yes ☐₂No
Specify

Optional Toxics Module

O. PAINT

◀For interviewer to read▶ Now I have a few questions about paint inside and outside your home.

O1. Has there been remodeling or paint removal on the inside or outside of your home in the last two years?

(If apartment, include inside spaces of building such as lobby or hallway)

A ☐₁ Yes ☐₂ No ☐₃ Don't know

O2. Are you or your landlord planning to remodel or repaint within the next 12 months?

A ☐₁ Yes ☐₂ No ☐₃ Don't know

O3. Does your building have asbestos (furnace insulation, "popcorn" ceiling)?

A + O Yes1
 No2 ➔Skip to O4
 Don't know.....9 ➔Skip to O4

O3a. ➔If yes, is the surface of the asbestos in good condition?

(i.e., not damaged, loose, or flaking)

A + O ☐₁ Yes ☐₂ No ☐₃ Don't know

O4. Is there a place to store chemicals that is separated from the living area so that fumes cannot get into the living space, such as a shed or detached garage?

A Yes1 ➔Specify location _____
 No2

O5. Does anyone do hobbies or crafts in the home?

A Yes1 ➔Specify _____
 No2

O6. Are there members of the household who work with hazardous materials on the job? (such as asbestos, batteries, lead, mercury, paint or pesticides).

A Yes1
 No...2 ➔Skip to next section
 Don't know9 ➔Skip to next section

O6a. Before coming home, do they ?

O6a1. Change clothes.... ☐₁ Yes ☐₂ No ☐₃ Don't know

O6a2. Change shoes ☐₁ Yes ☐₂ No ☐₃ Don't know

O6a3. Shower..... ☐₁ Yes ☐₂ No ☐₃ Don't know

O6b. Are their work clothes laundered separately from the family wash?

☐₁ Yes ☐₂ No ☐₃ Don't know

P. SAFETY

P1. Is lighting adequate for safety for the following places?

O	Yes	No, no light fixture	No, light bulbs burned out	Not applicable
Hallway	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
Staircase	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
Porch/front door	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
Walkway to house	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉

P2. Are the following structures in poor or deteriorating condition in any area of the home,
inside or outside?

A + O

Stairs	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No	<input type="checkbox"/> ₉ Not applicable
Railings	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No	<input type="checkbox"/> ₉ Not applicable
Porches and balconies	<input type="checkbox"/> ₁ Yes	<input type="checkbox"/> ₂ No	<input type="checkbox"/> ₉ Not applicable

P3. Is there a working smoke detector on each floor in your home?

(test detector by pushing test button)

A + O

Yes1
 No - battery dead.....2
 No - no detector or broken3
 Can't test8
 Don't know.....9

P4. Is there a poison center number on or near the phone?

A + O ☐₁ Yes ☐₂ No ☐₉ Don't know

P5. Is there Syrup of Ipecac in the home?

A + O ☐₁ Yes ☐₂ No ☐₉ Don't know

P6. In case of fire do you have at least 2 ways to get out of your home? (*ways include a fire escape, exit door, balcony, window you can crawl through, or stairs from a public hall*)

☐₁ Yes ☐₂ No ☐₉ Don't know

P7. Are any firearms now kept in or around your home? Include those kept in a garage, outdoor storage area, car, truck, or other motor vehicle.

A + O Yes1 ► Ask Q7a & Q7b below.
 No2 ► Skip to end.
 Don't know/refused.....9 ► Skip to end.

P7a. Are any kept loaded?

A + O ☐₁ Yes ☐₂ No ☐₃ Don't know/refused

P7b. Are any kept unlocked?

A + O ☐₁ Yes ☐₂ No ☐₃ Don't know/refused

P8. Are there any non-asthma medicines in the home accessible to children?

A Yes1 ✎ Specify names of medicine _____
 No2

	P9	P10	P11
Are there any: A + O	Flammable products stored near fire or heat?	Hazardous products within reach of children?	Damaged, rusting, leaking or open containers of hazardous products?
	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
If yes:			
What is the product?			
Where is it stored?			

Thank you very much for allowing me to walk through your home and for answering these questions.

TIME AT THE END OF THE INTERVIEW: ____:____ ☐ AM ☐ PM